DOCUMENT RESUME

ED 363 007 EA 025 393

AUTHOR	Thomas, Carol F.; And Others
TITLE	Moving toward Integrated Services: A Literature Review for Prevention Specialists.
INSTITUTION	Western Regional Center for Drug-Free Schools and Communities, Portland, OR.
SPONS AGENCY	Department of Education, Washington, DC.
PUB DATE	Sep 93
CONTRACT	S188A00001
NOTE	49p.
PUB TYPE	Reports - Descriptive (141) -- Guides - Non-Classroom Use (055) -- Information Analyses (070)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	*Agency Cooperation; Community Services; Elementary Secondary Education; Prevention; Program Implementation; *School Community Relationship; *Social Services
IDENTIFIERS	*Integrated Services

ABSTRACT

This document was written for prevention specialists who plan or implement integrated services in their communities or school districts. Chapter 1 explains why integrated, school-linked services are needed. Chapter 2 outlines the elements of successful integrated services and barriers to implementation. The third chapter describes three approaches, ranging from the categorical model (the simplest), the student-focused model (midrange in the continuum), and the integrated-services model. The final chapter describes six integrated-service programs in the western United States and lists contact organizations. Four figures and one table are included. Appendices contain a matrix depicting elements of success and a recommendation form for successful integrated-services programs. (LMI)

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Western Regional Center
DRUG-FREE SCHOOLS AND COMMUNITIES

ED 363 007

MOVING TOWARD INTEGRATED SERVICES:

A LITERATURE REVIEW FOR PREVENTION SPECIALISTS

September 1993

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The contents of this publication were developed under Cooperative Agreement Number S188A00001 with the U.S. Department of Education. However, the contents do not necessarily represent the policy of the Department of Education, and endorsement of the contents by the federal government should not be assumed.

MOVING TOWARD INTEGRATED SERVICES: A LITERATURE REVIEW FOR PREVENTION SPECIALISTS

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September 1993

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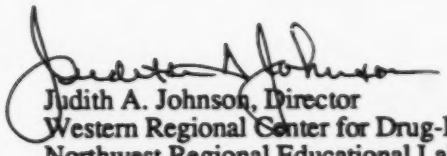
PREFACE

The Western Regional Center for Drug-Free Schools and Communities works with schools and communities to develop and implement comprehensive alcohol and other drug (AOD) prevention and early intervention programs. Prevention specialists in communities and schools are becoming leaders in the integration of social services for youth. Some schools have had student assistance programs for some time and others are beginning to form partnerships with community-based service agencies. Integrated services provides a more comprehensive system for prevention specialists to identify and provide needed alcohol and other drug prevention and intervention services for youth and their families. This document was developed for prevention specialists to provide an overview of the literature on integrated services and to provide a rationale for this approach.

We encourage you to share your successes with us. Integrated services is a relatively new approach being implemented in states in the Western Region. Few models have been documented and evaluated. We have only begun to learn about the many models, successful programs, practices and school-health community partnerships that are forming. We hope you will help us in this search and use the recommendation form provided in the Appendix of this document.

The authors and I appreciate and thank the following persons for their thoughtful review of drafts of this document: Cindi Moats, and Arlan Neskahi, at Southwest Regional Laboratory (SWRL); and Ralph Baker, Bethann Berliner, and Robert Linquanti, at Far West Laboratory (FWL). In addition, thanks go to Colleen Montoya, SWRL, for editing the document.



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INTRODUCTION

"An increasing number of schools are beginning to view themselves as community institutions, serving as the locus for providing a number of social, health, and supportive services to families." (Blank & Lombardi, 1992)

An informal poll taken at the National Association of Secondary School Principals' annual convention in March 1991 asked principals if they agreed or disagreed with the following statement: "Schools that attempt to teach academics and provide social services are doomed to fail." Approximately 110 principals agreed with the statement; but 165 disagreed. The 165 principals who have been or think they can be successful at providing students with needed social services probably recognized that various student problems are related and principals have a key role to play in working with others to address these problems. Since that poll was taken, interest in the integration of school-linked social services has increased as many schools have moved to implement various models of integrated services.

School-linked services are part of a larger movement toward the integration of education, health, and social services to solve problems of service fragmentation, overlap, and lack of access and availability. The vision of this integration is for all agencies in the community to be child-centered and to increase the likelihood that all children will be healthy during their important developmental years. This can be accomplished through increased collaboration and partnerships among service agencies to develop and work toward this common goal.

School-linked *service integration* generally means that (a) services are provided to children and their families through collaboration among schools, health care providers, and social service agencies; (b) services are planned and administered in collaboration with school staff; and (c) services are provided at or near schools. The term *collaboration* used here means efforts that go beyond information sharing and even coordination, to include a blend of service agency goals and actions.

There have been few empirical evaluations of integrated service models. Most of the literature reviewed for this document are papers advocating integrated services, policy briefs, observations of the few current programs and syntheses of this literature. We think a consensus exists that the various problems facing youth are inter-related. Therefore, the realization that this network of problems can not be adequately addressed by individual agencies acting alone, but only by comprehensive services from networks of coordinated, collaborating, and cooperating providers is emerging.

This document was written for prevention specialists who plan or implement integrated services in their communities or school districts.

It has three purposes: (a) to review the literature on integrated services; (b) to provide a rationale for integrated services; and (c) to identify additional resources for prevention specialists involved in integrating social services.

WHY INTEGRATED, SCHOOL-LINKED SERVICES?

> *"Proponents of integrated services believe that poor education, health, and social outcomes for children result in part from the inability of the current service systems to respond in a timely, coordinated, and comprehensive fashion to the multiple and interconnected needs of a child and his or her family." (The Future of Children, 1992).*

The needs of many youth and their families are so broad and complex that they go well beyond what schools can provide. The role of the school is to create an environment in which children can learn and grow to be independent adults. Students learn and grow best when their emotional, social, and health needs are met. Many youth come to school with a variety of problems that are non academic and interfere with learning. To reach the goals of education, these issues must be addressed. Educators realize that they have neither the expertise, the time, nor mandate to meet the escalating health and social service needs of today's youth. Most of all, they lack the funds and other resources to do so (Ooms, 1991). Educators realize that they can't do it alone (California Department of Education (CDE), Not Schools Alone, 1991).

In addition to the fact that schools and/or communities cannot afford to do the job alone, the most compelling reasons to restructure the social service system and move to the integration of services are:

1. youth must be healthy to learn.
2. youth's problems are persistent, complex, and interrelated, particularly among economically disadvantaged populations.
3. social services are fragmented and difficult to access by youth and many families.

Youth Must Be Healthy To Learn

Schools recognize the relationship between academic performance and problem behaviors exhibited by youth (Austin, 1992). The National Commission on Children (1991) suggests that 40% of the nation's children are at risk of school failure. Meeting basic health care needs is an important prerequisite for achieving our educational objectives. As a result, educators are looking at their own settings as vehicles through which not only education but mental and physical health services can also be provided. The following statistics indicate the urgency of responding to these health needs:

1. Over 30% of American children were not immunized against measles, mumps, and rubella in 1990, and in many cities, the percentage increases to 50% (Department of Health and Human Services (DHHS), 1991).

2. 2.0 to 5.5 million children experience hunger (National Commission on Children, 1991).

3. Nearly 20% of children report no contact with a physician in the past year for preventive care. Conditions that can be corrected often lead to more serious illness or disability (National Center for Health Statistics, 1991).

4. Approximately 19% of all children have no health insurance (Hodgkinson, 1990).

Not only are basic health care needs not being met, but youth also are engaging in health compromising behaviors. Alcohol and other drug (AOD) use among youth is at unacceptable levels and is causing other health and social problems in our communities. Data from the 1990 National Household Survey on Drug Abuse and the Monitoring the Future Study (Johnson, 1992) indicate that 89.5% of high school seniors have drank alcohol, 64.4% have smoked cigarettes, and 47.9% have experimented with illicit drugs (National Institute on Drug Abuse (NIDA), 1991). Long-standing research documents the effects of AOD use on learning.

Youth Problems Are Persistent and Interrelated

Education and social services institutions have implemented a variety of programs to help youth with their problems, but the problems persist despite our best efforts. Many of them are chronic and intractable, such as poverty, abandonment, emotional and sexual abuse, chaos and violence, malnutrition, multiple unmet health needs, and little attention to the academic needs. These in turn create a number of additional, related problems:

1. In 1990, teenage mothers accounted for 13% of all births and 68% of these births were to unmarried mothers. Poverty is much more common among young mothers than delayed child bearers (National Center for Child Poverty, 1992).

2. In 1990, almost one out of four U.S. children under age six were living below the poverty line (National Center for Child Poverty, 1992).

3. More than one quarter of all poor children under six live with single parents who work full time or with married parents who together work the equivalent of one full time job or more (National Center for Child Poverty, 1992).

4. Estimates vary, but between 68,000 and 500,000 children are homeless each night in the United States (Children's Defense Fund, 1991).

5. Unintentional injuries is the leading cause of death for children through age 14 (Department of Health and Human Services (DHHS), 1990).

6. Injuries, homicide, and suicide, all preventable, are the three leading causes of death for youth, ages 15 through 24 (DHHS, 1990).

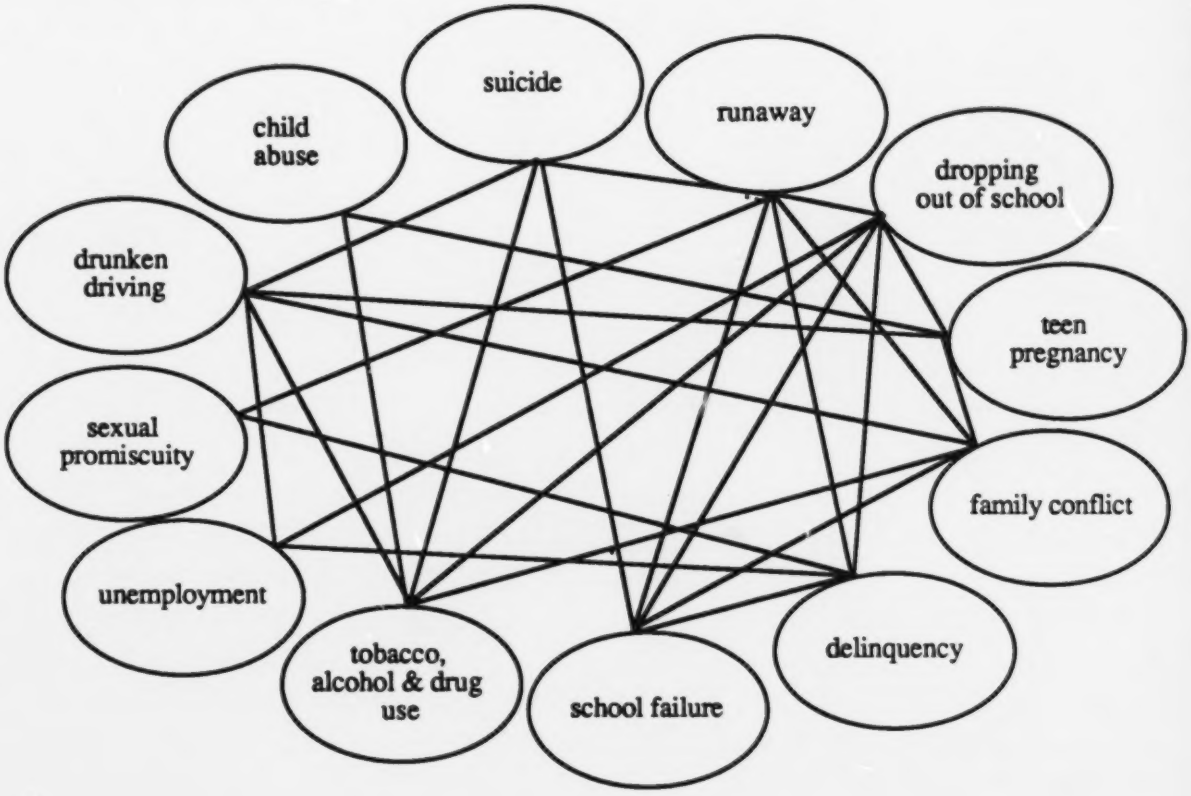
7. Psychological, emotional, and learning disorders are on the rise among children, as are chronic physical conditions such as hearing and speech impairment. Low-income children are at a significantly higher risk for such problems (DHHS, 1990).

A youth experiencing one problem always is experiencing related problems. A family experiencing one problem always is experiencing related problems. Figure 1 shows the network of interrelated problems. A child's social, health, and academic behavior depends upon the influences within the family, school, community, and peers. Children at risk of school failure come from multiple problem families (Kaplan, 1986). These problems are both internal and external, and include poverty, isolation, high stress levels, and an inability to access social support and resources. Many of these families do not improve in response to help and often request help only when acute problems arise. Some families are overwhelmed with problems and need the school to help them identify their own or their children's needs and facilitate providing services for them.

The use of alcohol and other drugs is a good example of the connections between problems. AOD use is directly related to a host of education, health, and social problems (Jessor, 1985). The use of cigarettes, alcohol, and marijuana increases the risk of the use of other illicit drugs. The use of these drugs is correlated with other health problems, including adolescent suicide; homicide; school dropouts; motor vehicle crashes; delinquency; and precocious sexual activity and unwanted pregnancy (National Institute on Drug Abuse, 1985; Silverman, 1989; Lorion, 1991). Other recent research indicates that AOD use increases the risk of HIV transmission. The resulting combination of problems often appears at school in the form of poor academic performance.

Many of the family, personality, and behavioral risk factors that predict AOD use already are evidenced during the elementary years--and even earlier. This enables us to identify and intervene with those children based on these characteristics (Kellam, Ensminger, & Simon 1980; Block, Block, & Keyes, 1988). Many of the same early problem behaviors that predict later AOD use also predict delinquency, dropping out of school, teen pregnancy, and so forth (Hawkins & Catalano, 1992).

Figure 1:
Web of Interrelated Problems



From *TOGETHER WE CAN Reduce the Risks of Alcohol and Drug Abuse Among Youth*
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Service Delivery Is Fragmented

Neither schools nor social service and health systems address this web of problem behaviors in an integrated manner. In fact, the families with the most severe problems and the most limited resources are likely to experience the most disorganized social service delivery system (National Commission on Children, 1991). In any school or community, there are usually several different planning groups with the same goal, but separate programs, curricula, and activities. This results in duplication, inefficient use of resources, and a system that allows youth to fall through the cracks.

The type of services a youth receives often depends on the problem initially identified. Other needed services that may fall within the domain of another social service system are not provided. This inefficient, disconnected approach to service delivery limits our ability to provide effective, integrated services that regard the issues confronting youth as holistic. The result is overlapping and unresponsive program services. No single social service provider is likely to assist the youth in a comprehensive service plan.

A crisis response to services is reinforced by the eligibility criteria established by various programs. For example, in schools, academic tutoring may not be provided until after a student already has fallen so far behind in coursework that he or she is failing. Responding to a crisis as opposed to preventing one from occurring contributes to the high social costs associated with various problems youth experience.

The ability of agencies, including schools, to provide comprehensive programs often is limited by the restrictions dictated in the funding regulations. Unfortunately, the categorical funding restrictions initiated at the federal level limit the ability of states and local agencies, including school districts, to implement integrated, comprehensive programs. Services are provided within categorical areas rather than across service categories and usually are fragmented. Adding to this fragmentation are state and district program coordinators for separate issues (English, 1992). Generally, service providers do not meet regularly to coordinate efforts or reduce the barriers, impeding efforts to share service delivery and better serve youth.

The above conclusions were reinforced by a report (Melaville and Blank, 1991) that identified several problems with the current system of providing education, health, and social services for children:

1. Most services are crisis oriented.
2. The current social welfare system divides the problems of children and families into rigid and distinct categories that fail to reflect their interrelated causes and solutions.
3. There is a lack of functional communication among public and private service agencies.
4. There is the inability of specialized agencies to easily craft comprehensive solutions to complex problems; and
5. Existing services are insufficiently funded.

Providing discrete, fragmented services results in other problems. The personnel within each service agency have differing beliefs about children and their orientation to their profession, and they concentrate on their own agency service goals. To complicate the problem, historically, adolescents have had low access and use of the social services and health system. Youth, while wanting autonomy and privacy, are still dependent on parents who usually must provide permission for youth to receive services. This is further complicated for youth who come from dysfunctional families where parents are unable to assist them in accessing services. Many young people have no transportation and may lack confidence in dealing with the system. In addition, the climate of some agencies is either totally adult- or child-oriented.

Morrill (1992) further explains that, in addition to the above restrictions to services, the present system of follow-up for youth is insufficient. Mechanisms to ensure return visits by clients may not be part of the provider's procedures. If a family already is having problems, it may be an additional burden to find their way through the maze of service agencies. In addition, the rules and regulations of various social service agencies and their funding sources impede the development and implementation of creative strategies to serve families. Sometimes it is not even the rules themselves but the perception that "it can't be done" that restricts innovation.

In summary, barriers such as categorical division of services and staffing; lack of communication; rules and regulations of agencies and sponsors; limited access to services; and insufficient follow-up all contribute to fragmented service delivery for children and their families. These barriers to providing integrated services that address the complex, interrelated problems confronting our youth must be overcome if we are to enhance the potential of youth to achieve academic and personal success.

ELEMENTS OF SUCCESS

"Change is a process, not an event." (Hall and Hord, 1987)

Based upon a review of the literature, this section offers recommendations for a successful integrated service approach and strategies for overcoming barriers to implementing integrated services. This section summarizes some of the components that contribute to successful integrated service efforts. Appendix A includes a table that summarizes several review articles that specifically cited elements of success.

Lessons From the Literature

Those contemplating, planning, or implementing integrated services would be well advised to reflect on the lessons cited in various reviews and policy papers. The following authors provided broad, general recommendations. Edelman and Radin (1991) closed their paper, *Serving Children and Families Effectively: How the Past Can Help Chart the Future*, with several lessons:

1. *Awareness of limited resources.* Program planners need to develop and implement program goals to match availability of resources or their programs are doomed for failure.

2. *The need for diversity and collaboration.* The idiosyncrasies of a state, locality, or a neighborhood can determine the effectiveness of a particular program. Change requires partnerships among many people.

3. *The effects of complexity.* Seemingly simple strategies for change create numerous problems and unintended consequences. Addressing one set of problems may create other difficulties.

3. *The need to build synergy.* The problems faced by families are interrelated and interdependent. Our programs must build on one another and operate in a related way.

In a commentary to Edelman and Radin, Gardner (1991), added additional insights. For example, he emphasized the need for system planning, including a radical change in the design of funding streams. He suggested that a "new consensus" requires that service integration efforts be based on a notion of mutual obligation. An important lesson he cites is that outcome measures are critical to knowing where you are going. Determining and evaluating desired outcomes should be part of the initial system planning.

In their document, *Together We Can* (1993), Melaville, Blank, and Asayesh reflect that even those who agree on a common goal, and share staff and accountability, can become so absorbed in designing individual projects to help families that they never accomplish system change. They call this "projectitis": the tendency to add new programs to existing systems without developing mechanisms to expand successful innovations and improve outcomes throughout the community for everyone with similar needs.

The field of school-linked, integrated services is so new and the programs so complex that few attempts have been made to conduct any comprehensive evaluations. The evaluation data that have been reported usually relate to use patterns and the types of services being provided to families (Ooms, 1991), as opposed to the *effect* of service delivery on measurable *outcomes* for youth.

Premature pressure to evaluate still developing programs is a concern (Dolan, 1992).
The unusual nature of integrated services programs presents particular challenges to effective evaluation. In a recent paper, Romero (1992) raises three challenges. First, the complex nature of the partnerships (a critical and unique element of the program) will make it difficult to draw accurate causal inferences about program outcome and impact. Second, integrated services programs comprise a fairly long and complex sequence of process events required to achieve desired program outcomes, each of which must be executed with at least moderate effectiveness. Finally, because integrated services are very much evolving programs, plans and approaches are likely to change during the first few years, making it critical to capture changes in the program at periodic intervals.

Overcoming Barriers

Everyone seems to want good planning to avoid problems and overcome barriers to implementing integrated services. Levy and Shepardson (1992) suggest five questions to ask in planning a promising school-linked service strategy: (a) What is the primary purpose or objective of the strategy? (b) Who is to be served? (c) What services will be offered? (d) Where will services be located? and (e) Who will be responsible for service delivery? As basic as these questions sound, they are not always easy to answer.

Not surprisingly, good communication with agency partners is cited frequently. Because so many youth with health problems also experience problems in the classroom, it is easier for health and education staff to communicate with each other when they are in close proximity. However, true collaboration is difficult to achieve--it requires good communication and coordination as first steps.

A topical synthesis by Cotton (1991) reviews the literature on school-community collaboration and provides a good summary of effective strategies and promising practices. Her review suggests that successful school-community linkages are those where all the key players are involved and where staff members are given the time, training, and skills--including multicultural awareness and communication skills--to establish and maintain these sustained and supportive relationships.

Good communication means sharing information. Sharing information among various agencies brings up the issue of confidentiality. Laws protecting confidentiality often are cited as barriers to implementing integrated services. An extensive study of what barriers existed to the sharing of confidential information among agencies was done by the San Diego County Department of Social Services (1991). They found that most barriers to the safe and open exchange of confidential information are management issues (Payzant, 1992). Another good discussion of confidentiality and successful strategies for information sharing for effective coordination of services is included in Behrman's *The Future of Children* (1992) and Greenberg, Levy, & Palaich's *Confidentiality and Collaboration: Information Sharing in Interagency Efforts* (1992).

In addition to time for collaborative planning and good communication, many authors brought up issues related to shared governance, the restructuring of budgets and funding streams; and the development of policies at the national, state and local level. For example, Nissani and Hagens (1992) discussed developing synergistic procedures and processes. They suggest that all agencies work to eliminate unnecessary regulatory measures, policies, or activities that support fragmented services to families. This may entail legislative advocacy at state, federal, or local levels. This approach suggests the merging of funds to promote cost reduction and cost benefit and may include the participation of public/private partnerships to enhance resources and to ensure community investment in the process.

Other documents cite similar barriers. A document published by the state of Florida (1993) identified seven major barriers that need to be solved: lack of understanding; lack of resources; funding procedures; information system/sharing; management/coordination/collaboration; involvement/participation; and mobility. For each of these barriers, they listed problem statements, cited causes, listed proposed solutions, and suggested actions to be taken by their work group. The West Virginia Education Association, along with the Appalachia Educational Laboratory, has conducted a study that concluded there is no one blueprint for school-linked social services (1993). Their guidebook, however, includes recommendations for establishing school/community social-service programs and suggestions for funding and technical assistance.

Building on Lessons Learned

Building on the lessons learned from past programs, various program developers and researchers have proposed components or critical elements that should be included in successful integrated service programs. Yet to be tested is determining which elements work in what situations and what combination of components is best. Many of these programs have not been systematically evaluated. Table 1: *Elements of Success*, in Appendix A, identifies many of the elements of success mentioned by various authors. The ones that are bolded in the table were cited by five or more authors and should be included in planning discussions regarding integrated services. These elements involve aspects of planning, family/community issues, service delivery, governance and funding, staffing and training, and evaluation.

Aspects of service delivery also were mentioned frequently. Melaville and Blank (1991) suggested that interagency partnerships to accomplish integrated services have to share a common understanding of what constitutes high quality service delivery. They proposed the following elements:

1. A wide array of prevention, treatment, and support services must be offered.
2. Comprehensive service delivery must include techniques to ensure that children and families actually receive the services they need.
3. A focus on the whole family must be maintained.
4. High quality services must empower children and families.
5. The effectiveness of high quality prevention, support, and treatment services must be measured by the impact these interventions have on the lives of the children and families (pg. 9-11).

In their study of current integration efforts in the Northwest, Nissani and Hagens (1992, pg. 8) identified the following key elements of successful integration related to service delivery:

Family Centered Service Delivery	The family, rather than the child or a specific adult, is the service unit or client. All aspects of service delivery incorporate the perspective of the family unit. Services rendered to individual families are culturally relevant to the family unit.
Comprehensive Service Focus	Services encompass more than one specific need of the family unit. Projects or programs of the integration address two or more needs of the family, sharing agency expertise for the benefit of the entire family.

Prevention Orientation	The integration seeks to strengthen the family unit rather than remediating its weaknesses. A proactive approach to services rather than a reactive approach is applied. A preventive approach makes community services available to families so as to prevent future interventions or treatment.
Empowerment Focus	Families or members of families are encouraged to take an active role in the development, implementation, and evaluation of integrative services. Programs are designed to assist families to build support networks, capitalize upon their strengths, retain their autonomy, and avoid agency dependency. This approach is modeled in the integration itself, through consensus building decision making processes, shared vision and mission statements, and collaborative leadership.
Local Community Focus	Whether the integration is a statewide attempt to alter the system or a local attempt to impact service delivery, the integration of services will be defined in terms of local community needs. A state-wide integration that examines systems offering family support will need to be developed in a flexible manner to encompass the diversity of needs of individual communities. This "grassroots" input becomes a part of the decision making process at all levels of integration.

Behrman (1992) lists seven emerging criteria for school-linked services that touch on aspects of planning, governance, and service delivery:

1. The participating agencies will have to change how they deliver services to children and families and how they work together.
2. The planning and implementation of school-linked services should not be dominated by any one institution--schools or health or social services agencies.
3. School-linked services should be comprehensive and tailored to the needs of individual children and their families.
4. Each agency participating in school-linked service efforts should redirect some of its current funding to support the new collaboration.
5. School-linked service efforts should involve and support parents and the family as a whole.
6. School-linked service efforts should be both willing and able to collect data about what is attempted and achieved and at what cost.
7. School-linked service efforts should be able to respond to the diversity of children and families.

Ooms and Owens (1991) suggested six ideal characteristics of a system designed for youth and their families: (a) Easy access and convenient; (b) trained, caring providers; (c) coordinated, continuum of services; (d) provision for individual counseling; (e) patient confidentiality; and (f) family-friendly services.

These lists could go on and on. Many other literature reviews, policy briefs, advocacy documents, and program descriptions included some similar elements. As mentioned earlier, the field is so new, the goals so numerous and the programs so complex, that few attempts have yet been made to conduct any comprehensive evaluation of school-linked integrated services and their effects on child wellness measures. Evaluation of processes and outcomes is an important element of successful programs (Payzant, 1992). Questions of program impact need to be developed, but not before the program reaches a stable level of activity. In the meantime, programs need to gather good descriptive data in the early stages of program implementation.

MOVING BEYOND CATEGORICAL ISSUES

> *"There are many interventions and many programs that do help, including many that demonstrably help multiple-problem families. Nonetheless, while some families and some individuals within families can be helped by individual programs, broad progress depends on employing our endeavors in tandem." (Edelman & Radin, 1991)*

All schools have some process for helping students with their problems. These processes can be discussed and analyzed by placing them on a continuum from simple to complex. Integrated service approaches, the most complex systems, have most or all of the *elements of success* displayed on Table 1 (Appendix A) and referred to in the previous section of the paper. Simple systems, such as categorical approaches, have few of these elements. Those in the middle, student-focused approaches, have some of the elements of success but are still school-governed. Complex systems have the best capacity for providing a healthy environment for students and staff through a coordinated set of prevention, intervention, and after care programs.

Every process is different, depending on the school and community context. Some have similar names such as *Student Assistance Program*, but they have different features. We have divided this continuum into three discrete types to compare the advantages and disadvantages of each. We hope this section will not only help prevention specialists analyze their own systems but also provide information for improving their systems.

The simplest systems provide short-term intervention for problem behaviors by responding to episodes. One of their main goals is to find solutions for a crisis or an immediate problem. Because simple systems are not integrated into general educational processes, they are person dependent. Lack of continuity and consistency from year to year keep them isolated and undervalued.

Processes in the middle of the continuum have the capacity to provide early intervention and to respond with a broad range of on- and off-site student supports. These are usually described as Student Assistance Programs (SAPs). Problem behaviors can be treated as symptoms of more complex problems rather than as episodes to fix. Common characteristics are involvement of school staff; management by a team rather than a person; commitment of the school-site leadership; integration of general and other funds; provision of prevention and aftercare programs as well as intervention; and agreements with community agencies.

Complex processes are institutionalized systems that provide an array of services to students, staff, families, and communities. The most distinguishing feature is shared governance through school-community collaboration. The needs of the families and communities drive the system, not just the needs of the school or of specific funding sources. Multiple problems are treated with coordinated action on several fronts. As a result, services for widely different needs and diverse populations can be offered so families get the help they need in an environment they trust.

This section discusses how schools and communities can move on the continuum, from a categorical issue-driven approach or a school-based student-focused approach toward an integrated services approach. It discusses the differences between these various approaches and draws some insights for prevention specialists.

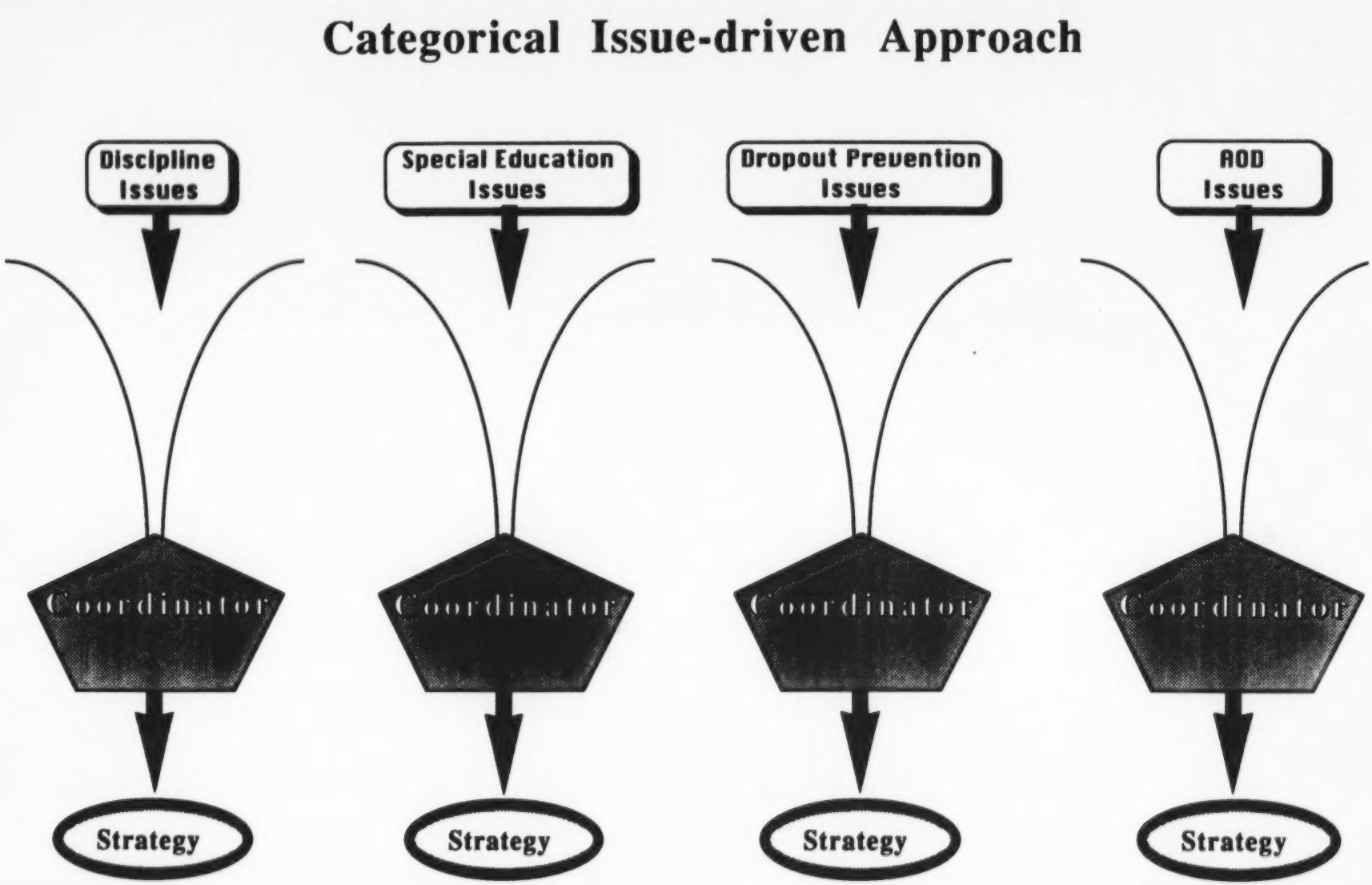
Categorical Issue-driven Approach

Categorical approaches are on the simple end of the continuum because their main goal is to meet specific needs of carefully defined target populations. Developed for short-term grants or federal and state mandates, such as special education, schools and community service agencies alike have been forced into creating several parallel and discrete systems for identifying and helping youth.

Categorical, single issue-driven approaches, illustrated in Figure 2, are neither successful nor cost-effective in helping students. Problems get managed, but they don't get solved. For example, short-term management of a problem might result in a student receiving a few days suspension, a one-time meeting with a counselor, or a parent contact. Or, one problem such as truancy, might be handled in depth, but other related-problems are ignored. The student will find another way to act out until the problem causing the truancy is addressed. Long-term solutions to prevent future problems are rarely used, because resources are so limited. Students with addiction problems, such as eating disorders or AOD use, can easily manipulate these categorical processes because there is no time to gather and share information. Enabling and denial flourish in the absence of good communication.

Sometimes, due to eligibility criteria imposed by separate funding streams, one staff person can even be prohibited from helping students who do not fit the criteria. A good illustration of this is AOD funding sources. Alcohol funds frequently specify that services can only be delivered to students who use alcohol. Students with other drug problems, such as marijuana or cocaine use, must be treated with funds originating from another funding source. Staff get discouraged trying to work within these artificial distinctions because AOD use by students invariably is connected.

Figure 2:
Categorical Issue-driven Approach



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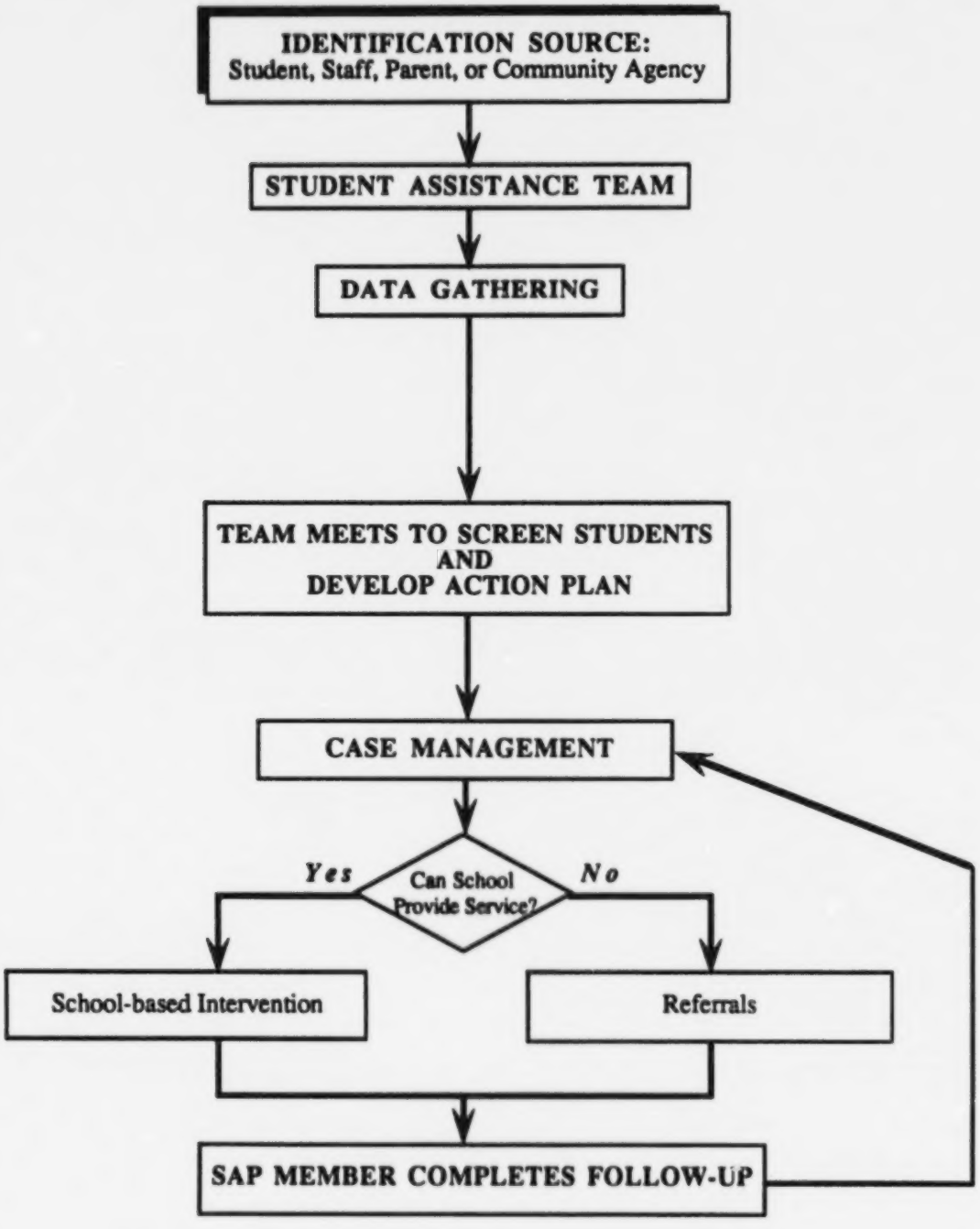
Multiple identification forms and behavioral checklists also illustrate the limitations of categorical programs. One identification form and process can exist for students with learning problems while on the same site, another form and referral process can exist for youth believed to have AOD problems. Still another form and process can exist for dropout prevention programs, juvenile gang diversion, or teen pregnancy prevention. Depending on the size of the school, one site might have five or six separate referral and screening processes, with little or no communication between them. It's very possible for one student to be identified through a number of referral systems simultaneously. When no one catches the overlap, teachers can end up filling out several behavioral checklists on the same student. Duplication of effort results. It's also possible for one student to be referred through one process but then dropped without referral to another process. For example, a student could be suspended by a dean or assistant principal for vandalism or some other problem behavior without the student being identified for assistance through one of the other resources. The student then falls through the cracks, the problems worsen, and the solutions narrow.

Other limitations of this approach relate to staffing and training. Case managers are not appointed to monitor and follow-through; staff members in one referral process are not trained to help with a variety of problems; individuals who identify students don't always funnel the referrals into the appropriate channels and valuable time is lost; and the school site as a whole gets discouraged and tired from trying to help, and consequently makes very little visible progress.

Student-Focused Approach

What seems to be working in some schools is a student assistance program (SAP) where a student-focused, interdisciplinary team, screens and reviews various strategies for students (Pollard, 1993). A SAP is not just a program to provide support services to students with problems; it is a process for developing and maintaining a healthy school environment. As an institutional commitment to providing coordinated programs to help students, staff, and families meet their personal, social, and emotional needs, it is permanent and consistent. This approach includes the following components: prevention, identification, data gathering, student screening, action planning, referral, and case management. Figure 3 depicts this approach.

Figure 3:
The Student Assistance Model



A SAP is different from a more complex referral process. Even through the goals are broader than a simple system, they are still closely tied to school success because they are school-governed programs. Alliances and communications with community agencies are common; however, mingling funds and sharing control are not. Many varied supports are offered on site to students, but they are directly related to increasing a student's ability to be successful in school and not to addressing broader social service needs.

Several features also distinguish a SAP from a simple system, placing it somewhere in the middle of the continuum. One, it is team driven. Referrals are handled through one central interdisciplinary team composed of school staff members from a variety of backgrounds. Membership rotates from year to year so all staff receive training and eventually have an opportunity to serve on the team. Two, all staff members assume some role in the SAP, such as planning, serving on the team, running a support group, covering co workers' classes, evaluating effectiveness, or assisting with paperwork. Three, students are given help and support through very early intervention, not just in response to an incident or episode. Four, prevention and after care, as well as intervention services, are offered to students on site through a variety of support groups, peer groups, mentors, and tutors.

A typical SAP intervention process begins when someone on site--staff, student, or parent--makes a confidential referral. Unlike categorical systems, students often refer themselves to student assistance or student-focused programs. This identification generates data-gathering instruments, such as a behavioral checklist, which are distributed to staff and others who know the referred student. Once the behavioral checklists, grades, attendance, and test scores are gathered, the team meets to review the information and develop a plan of action. Student supports can then be planned that take into account the whole student and not just one specific symptom. This plan may include referrals to on- or off-site support groups, a formal mental health or AOD assessment, special education testing, tutoring, counseling, mentoring, and peer support, among others. Instructional strategies, classroom placements, or course selections also might be affected. Once the plan has been implemented, continual reevaluation and collection of data ensures that the student is getting support.

Case management ensures the effective coordination of services and gives the student a positive message of caring and consistency. This student-focused approach incorporates the most common model, student or child study teams for special education, into the strategies. Students get referred to special education through the primary screening team.

SAPs go beyond looking at academic solutions for academic problems to looking at nonacademic solutions that increase academic success. However, many educational systems have moved even a step beyond the SAP model to an integrated services model.

Integrated Services Approach

A school-linked integrated services model also is student-focused, but it is different due to an emphasis on multiple agency, family-centered comprehensive health services. The integrated model is very similar to the SAP model, with the following exceptions:

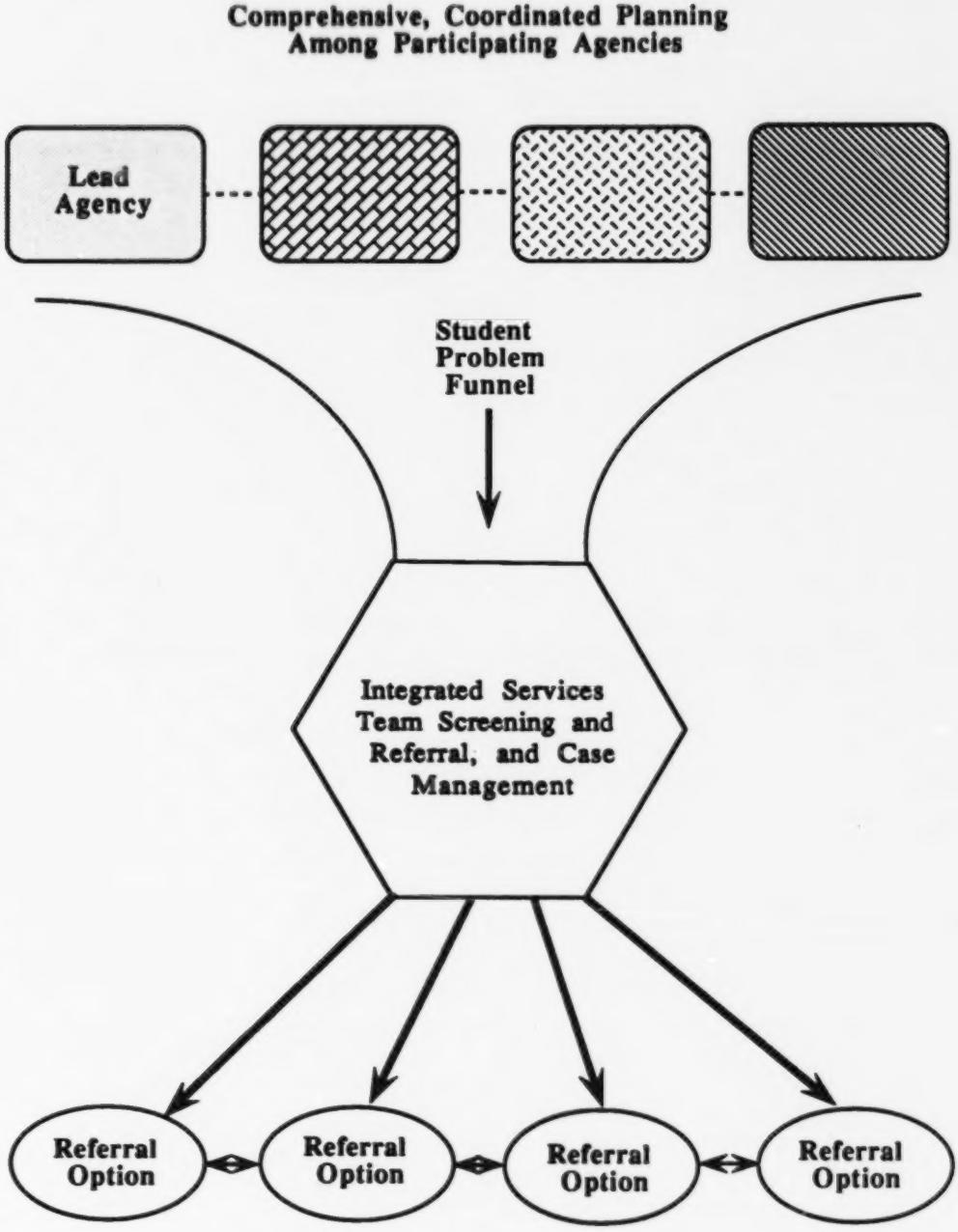
1. Teams include school staff and members from multiple community-based agencies.
2. Schools are not necessarily the lead agency, but an equal partner with a number of community agencies.
3. The number and type of referral options increase dramatically to include public, mental health, and social services, job search classes, literacy training, and family support, among others.

Figure 4 illustrates this approach.

Increasing team participation. Increasing the team participating in the integrated services process to include members from multiple community-based agencies has implications for how the team communicates. The literature on integrated services frequently uses the terms communication, coordination, and collaboration. Some authors define these terms, others seem to use them interchangeably. In fact, when planning for the relationships necessary for integrated services, a continuum of terms describes the extent of the relationships established:

1. Communication. In communication, the intent of the relationship is to share information. This is the easiest action to accomplish because it does not require any fundamental change in the way agencies do business.
2. Coordination. Coordination requires agencies to help each other meet his/her respective goals. This is an initial step for successful integrated services. However, agencies still do not have to make any substantial changes in the way they provide services, just coordinate existing services.
3. Collaboration. Collaboration requires that the partners establish common goals, plan together, pool resources, and implement and evaluate new services. Collaborative relationships not only coordinate existing services, but use resources differently to improve services.

Figure 4:
Integrated Services Approach



Working with multiple agencies to provide services to families and youth in the community will require all the agencies to contribute information and data useful for planning an integrated service delivery strategy and monitoring the outcomes of services provided.

Equal partners. Because of its stability and role in the lives of youth, the school district is an essential ingredient in any integrated services plan. Unlike the categorical issues approach or the approach using a SAP, the school is not necessarily the lead agency in an integrated services approach. This does not mean that school staff members should not provide leadership. They must partner and collaborate with other agencies in the community to develop a common mission.

Increase in referral options. With integrated services case management, the number of referral options increases to include immunization; dental; vision and prenatal care; substance abuse treatment services; help for dysfunctional families such as child abuse prevention and teen pregnancy prevention programs; academic support such as tutoring; nutrition screening; job search; family support; and so forth. The interagency partnerships are apt to include relevant local government agencies (e.g., health, social services), schools, community organizations, the private sector, and others. This might lead to developing new record-keeping forms that support not only one agency's needs but the information needs of another service agency. These partnerships are easier to build by keeping in mind the goal of simplifying access to services and increasing positive outcomes for families.

Integrated services models have many forms. Some systems are located on a school campus in a separate wing, trailer, or building where direct services are offered on site. Students and families can be referred by someone or they can self-refer, but they are initially screened through a multidisciplinary school and community team. Liability, confidentiality, supervision, and other issues of collaboration are spelled out in formal interagency agreements. Many conduct outreach and home visits, and most are open in the evenings and weekends.

Other integrated models are not located physically on a school campus, but in an accessible location close to the school and families. Some of these satellite programs are located in public housing units or churches. We are familiar with an integrated program operated from a storefront building in the center of an urban community. It was originally located in the back of the building but had little use. When it was moved to the front of the building, use increased dramatically. Because it was in the neighborhood and had child care facilities, many of the non working families volunteered in the center.

Still other integrated services units operate from mobile vans and travel through neighborhoods on rotating schedules. They have characteristics similar to the school-site and storefront offices, but they are designed to assist the most disengaged families who are at highest risk for problems. Integrated services systems can be organized in many ways as long as they are one-stop locations, use case management, employ diverse staff, and are convenient and accessible.

In summary, a shift in emphasis needs to be made regarding the approach and philosophy of social services for youth and families. Currently, the field is focusing on service delivery strategies and *talk* about collaboration. Integrating social services should give us the opportunity to change the outcome measures of child wellness. Such measures include reducing the number of early teen pregnancies; increasing the numbers of children who receive health screenings and are immunized; increasing school attendance and reducing the number of students who drop out of school; and increasing the number of youth who abstain from or stop using AOD. Agencies should jointly be accountable for changes in these outcome measures.

WHERE TO GO FOR HELP

> *"As more communities begin exploring the idea of a school-linked service strategy, they understandably are eager to extract from this experimentation "models" that can be replicated. Yet, from our perspective, a distillation and promotion of models is premature. The very diversity of efforts in itself defies categorization into a limited number of structures and approaches. Moreover, because the movement is still so young, there is a lack of hard evidence that what is being tried is indeed effective." (Levy & Shepardson, 1992).*

Each community is unique and therefore each integrated service partnership will reflect different values, culture, needs, and concerns. However, much is to be learned from reviewing the experience of others. This section includes some descriptions of integrated services programs in practice in the Western Region and have been described in the literature. The programs are discussed in terms of their background, services, and critical elements that appear to make the program effective. Even though many of these programs have not yet been evaluated, they provide a vision of what can be done in a variety of community contexts. They also offer an understanding of the elements of integrated services that may be worth replicating.

For a good discussion of theoretical models that have some relevance for the current times refer to the Edelman and Radin (1991) paper, *Serving Children and Families Effectively: How the Past Can Help Chart the Future.* The models they discuss focus on three different issues in the *service process*: service delivery and access models; planning and resource allocation models; and place-specific models. In addition, Kahn and Kamerman (1992) proposed four models of school-linked, integrated services. These four models also characterize various service processes: role expansion model; organizational expansion model; system supplementation model; and school-based community services model.

To get started, a school's first contact should be its county health agency to find out if any integrated service programs are implemented. This section of the paper includes a listing of agencies that you can contact for information or assistance in implementing integrated service models. These agencies include those that disseminate information and materials and develop policy documents, as well as those that offer technical assistance, provide training, and advocate for integrated services.

Examples of School-Linked, Integrated Services Programs

The following are some examples of school-linked, integrated service programs that are currently being implemented within the Western Region.

The Healthy Start Program

The Healthy Start Program, established by Senate Bill 620, is the cornerstone of Governor Wilson's 1991 initiatives designed to enhance prevention and early intervention programs for children in California. The program is administered by the California Department of Education. Healthy Start offers funding to school districts and county offices of education (LEA) and LEA consortia to create innovative, collaborative partnerships to meet the health, mental health, social service, and academic support needs of low-income children, youth, and their families. Planning grants and operational grants are available. The program's objective is to provide significant, prevention-oriented assistance for youth by establishing systems for integrated service delivery at or near school sites throughout California. The program has been evaluated. A minimum of four of the following support services are included in the programs: health care; mental health services; substance abuse prevention and treatment services; family support and parenting education; parent education, including job search skills; academic support; health education; youth development services; counseling; and nutrition services. Healthy Start programs include the following critical elements in their design: one-stop shopping; provide a minimum of four support services; target low-income children and family members; culturally appropriate systems; education and training for collaborative agency staff; and individualized case management.

Contact: Interagency Children and Youth Services Division, California Department of Education, (916) 657-3558

Multnomah County, Oregon

Since its first school-based health center in 1986, Multnomah County has established seven centers. Five of these are funded by the county and two receive partial state funding. During the time Multnomah County was establishing their centers, the state began funding other centers around the state. Eleven school-based health centers in 8 other counties receive state general funds from the Oregon Health Division. All of the clinics provide comprehensive care, management of chronic conditions, mental health services, health promotion, reproductive health, and AIDS/STDs education and prevention. Families are involved in mental health counseling whenever possible. Clinic staff also refer students and their families to other available resources in the community. Each clinic is staffed by a community health nurse and/or nurse practitioner and a health assistant and/or office assistant. Some have part-time mental health consultants. Schools provide space for the clinics, utilities, and custodial support. Clinic staff meet regularly with the school principal. Staff also devote time to classroom teaching on health-related issues. Each clinic has an advisory committee which includes parents, students, faculty, and a variety of community members. Sixteen clinics are administered by county health departments and two by school districts. Management responsibilities for the seven Multnomah County clinics are shared by a Program/Clinic Manager and an Operations Supervisor.

Contact: Multnomah County Health Division, (503) 248-3674

Project LEARN, Children's Bureau of Southern California

In October, 1991 a collaborative effort was launched in the Oak View and Westmont Elementary Schools located in the Ocean View School District in Huntington Beach, CA. A partnership was formed among the Children's Bureau of Southern California (CBSC), Orange County Department of Social Services, and the Ocean View School District. The four goals of Project LEARN are to: (1) improve family functioning such that parents are better able to meet the emotional, social, physical, and educational needs of their children; (2) decrease child abuse and neglect; (3) increase school outcomes for children age five through eight; and (4) establish a formal mechanism for collaborating agencies to coordinate and integrate services. A variety of services are provided by CBSC to attain these goals including: (a) time-limited, goal focused counseling that serves to improve communication, problem solving, and coping skills; (b) practical modeling and teaching in the home of parenting and family living skills; (c) case management; (d) parent education classes and parent support groups; (e) respite short-term child care; (f) transportation services; (g) 24 hour crisis support; and (h) child self-esteem groups. School-based services are also provided. These include: (a) homework clubs; (b) child self-esteem groups; (c) positive peer culture groups; (d) women's support groups; (e) parent development courses; and (f) parent-child stimulation classes.

Contact: Children's Bureau of Southern California, (714) 385-9025

New Beginnings

The New Beginnings effort is the result of three years of planning by a coalition of the San Diego City School District; San Diego County departments of health, social services, and probation; the Juvenile Court; the City of San Diego; the Community College District; the University of California, San Diego Medical Center; the Children's Hospital; and the San Diego Housing Commission. New Beginnings seeks to improve outcomes for children and families through restructuring education, social services, and health systems. The project is run by an Executive Committee comprised of heads of all partner agencies and a Council made up of managers from the same agencies. Services include comprehensive case management for families from a team of family services advocates--repositioned staff from the participating agencies. Case management includes ongoing counseling and service planning, as well as referral to education, social, and health services. Critical elements include resources from the participating agencies and assistance from the Stuart Foundations, the Danforth Foundation and California Tomorrow.

Contact: Office of the Deputy Superintendent, San Diego Schools, (619) 293-8371

Yamhill County Youth Services Team

This program began in 1987 after several years of informal linkage activity. The public schools have gradually become involved. The district coordinator, school counselors, and teachers participate in the referral process and are able to monitor the progress of referred youth. The team deals with youth from all nine school districts in Yamhill County. These youth and their families have multiple service issues. Some service is provided directly through team-related services. In most cases, the youth are assigned a case manager who works to refer the child and family to needed services. Regular communication and quick responsiveness from the team coordinator are critical elements of the program. The program has agencies, including school districts, redirecting funds to the project. The group functions as a policy board including representatives of service agencies, school districts, the employment council, and the sheriff's office. Yamhill County Health and Human Services Youth and Family Service Division administer this program through a part-time Team Coordinator.

Contact: Yamhill County Health and Human Services Youth and Family Service Division

Youth Information Management Task Force

Located in Yellowstone County, Montana, the Youth Information Task Force was established to make relevant case materials available to all agencies involved with referred youth and to share information. The program identifies and refers youth to appropriate agencies for needed services. Representatives from the appropriate agencies attend weekly Task Force meetings. The team identifies options, selects appropriate service strategies and coordinates the case management. A full-time coordinator is funded through a mix of funds from the county budget, the school districts, and the county drug-free consortium. This coordinator is housed in the Billings Public School District and even though anyone in the county can refer cases, most of the referrals come through the schools. An executive board oversees the group and a larger board monitors activity of the Task Force. Members of the Task Force include school districts in the county, the sheriff's office, police departments of Billings and Laurel, the Department of Family Services, and offices of the county commissioners court services and County District Attorney. The member organizations and individuals have signed a contractual agreement regarding confidentiality. As a result of the meetings and a combined case management approach, the agencies participating in the Task Force have started to eliminate duplication of efforts and increase service coordination.

Contact: Billings Public School District

Organizations to Contact

There are a variety of organizations and agencies that can provide assistance to school districts as they contemplate moving toward an integrated services approach. The following national, state and regional organizations can provide assistance, to include the dissemination of information and materials, development policy documents, technical assistance and training, and advocacy. Each agency is listed with an address, telephone number, and brief description. This limited list of organizations was selected for their specific interest in integrated services. Some of the publications examined as part of this literature review also included information about organizations and resources. For example, see *Together We Can* (Melaville, Blank, & Asayesh, 1993) for an extensive directory of key contacts and organizational resources.

Organization:	**The Center for Integrated Services for Families and Neighborhoods**
Address:	1620 6th Street Sacramento, CA 95814 (916) 446-9238
Description:	The Center is a project of the Western Consortium for Public Health. The Center was initiated in October of 1991. The Center's purpose is to reform the Human Service System. The activities of the Center include neighborhood-based innovative models; training, professional education, and research; conferences, publications, and consultation.

Organization:	**California Department of Education Interagency Children and Youth Services Division**
Address:	721 Capitol Mall, 5th Floor P. O. Box 944272 Sacramento, CA 94244-2720 (916) 657-3558
Description:	This division of the California Department of Education administers the state's Healthy Start grants and provides statewide leadership for integrating services to youth and their families. The Healthy Start Program, established by Senate Bill 620, is designed to enhance prevention and early intervention programs for children in California.

Organization:	San Francisco State University Integrated Services Specialist Project

Address:

School of Education
Department of Special Education
Integrated Services Specialist Project
1600 Holloway Avenue
San Francisco, CA 94132
(415) 338-1161

Description:

San Francisco State University has a graduate level certificate program in the area of collaborative human services delivery. It emphasizes the acquisition of competencies related to the delivery of school-based or school-linked services for students at-risk in the public school system. The program is interdisciplinary in nature and revolves around a 19 unit-three semester sequence of courses. It also includes field experience in which students are provided with the opportunity to apply course content on integrated and collaborative services to collaboratives in the San Francisco Bay Area. Stipends are available.

Organization:	Institute for Educational Leadership (IEL)

Address:

1001 Connecticut Ave., NW, Suite 310
Washington, D. C. 20036
(202) 822-8405

Description:

The Institute for Educational Leadership (IEL) is a non-profit organization dedicated to collaborative problem-solving among education, human services, and other sectors of communities. Their mission is to improve educational opportunities for youth by developing leadership skills and supporting leaders who collaborate. IEL convenes individuals and organizations from various sectors of the community to share perspectives.

Organization:	National Center for Service Integration (NCSI)

Address:

5111 Leesburg Pike, Suite 702
Falls Church, VA 22041
(703) 824-7447

Description:

The National Center for Service Integration is a collaboration of Mathtech, Inc., the National Center for Children in Poverty, the Children and Poverty Center, the National Governors' Association, the Yale Bush Center, and Policy Study Associates. In the Fall of 1991, the Department of Health and Human Services awarded a grant to this consortium to develop a national resource center to provide

information and support to the growing number of service integration initiatives around the country. A major goal of NCSI is to provide information and assistance on topics for which relatively little is currently available, and to facilitate dissemination of information and support that is available but not easily accessible. It undertakes a variety of activities through its Information Clearinghouse on Service Integration (see listing). Members of NCSI have written a number of publications on issues related to service integration.

Organization:	**Information Clearinghouse for Service Integration**
Address:	National Center on Children in Poverty 154 Haven Avenue New York, New York 10030 (212) 927-8793
Description:	The Clearinghouse collects and disseminates information and materials on service integration issues and related topics. They have developed a computer directory of service integration programs, a directory of organizations, and a research library collection.

Organization:	**Support Center for School-Based Clinics**
Address:	Center for Population Options 1025 Vermont Avenue, Suite 210 Washington, D. C. 20005 (202) 347-5700
Description:	This Center provides technical assistance to communities that are implementing health and social service clinics on school sites. The Center has published a comprehensive implementation guide. They also host national conferences on school-based services for administrators and service providers.

Organization:	**The Family Impact Seminar**
Address:	AAMFT Research and Education Foundation 1100 17th Street, NW, Suite 901 Washington, D. C. 20036 (202) 467-5114
Description:	The Family Impact Seminar (FIS) is a non-partisan policy research and education institute in Washington, D.C., founded in 1976, which works to promote family-centered policy at federal, state, and local levels. FIS examines the development, implementation, and evaluation of public and private policies and programs, as well as

builds capacity for family-centered policy among policy makers and governing institutions. They publish a series of reader-friendly background briefing reports (BBRs) which present non-partisan, state-of-the-art information on a wide range of family policy issues. BBRs are available on the following topic areas: adolescent health; families and schools; family poverty; foster care/family preservation; integrated services; substance abuse and children with special health care needs; and welfare reform and teen pregnancy.

Organization:	**Collaborative Services Technical Assistance Network (CSTAN)**
Address:	c/o California Tomorrow Fort Mason Center Building B San Francisco, CA 94123 (415) 441-7631
Description:	CSTAN was formed in November 1991 to create a forum for interested individuals to exchange information; share ideas about effective techniques and collaborative service models; and become better acquainted with each member's areas of expertise. CSTAN members are listed in a Resource Directory that contains in-depth descriptions of each individual or organization.

Organization:	**Center for Collaboration for Children, CSU Fullerton**
Address:	School of Human Development and Community Services California State University, Fullerton Fullerton, CA 92684 (714) 773-2166
Description:	The Center was established in 1991 by action of the Chancellor of the California State University system. With its 20 campuses, the CSU system annually produces more than 10,000 graduates who go to work in children-serving agencies. The Center is funded to support released time for eight Fellows at CSU Fullerton and has cooperative relations with three other campuses: CSU Los Angeles, Fresno State, and San Diego State.

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APPENDIX A

TABLE 1:
*Elements of Success**

Integrated Service Components:	Behrman, 1992	CSBA 1992	Jewett, Conklin, Hagans, Crohn, 1991	Levy and Shepard-son, 1992	Melaville and Blank, 1991	Nissani and Hagens, 1992	Ooms and Owens, 1991	Payzant 1992
Family-centered service delivery; responds to diversity of youth/families	X		X		X	X	X	X
Coordinated and comprehensive services	X				X	X	X	X
Prevention orientation			X			X		
Local community and empowerment focus	X	X	X		X	X		
Synergistic procedures and process; shared governance	X			X		X		X
Collaborative planning; Time for planning	X	X		X				X
Policy at all levels			X					X
Evaluation of processes and cost; joint data collection	X	X		X	X			X
Trained and caring providers; Cross-training for staff		X		X			X	X
Provision for individual counseling							X	X
Client confidentiality							X	X
Techniques to ensure that youth & families actually receive the services they need (e.g., co-location, one-stop shopping, case management); easy access and convenient			X	X	X		X	X
Restructuring of budgets and funding streams; Integrated budgets	X	X	X	X		X		X
Accountability and reward structures to emphasize positive outcomes				X				X

* In reviewing the literature some judgement was made regarding these categories. Not having a check in anyone element may not mean that a particular author did not think it was important. Integrated service components being cited by five or more authors is bolded.

APPENDIX B

Western Regional Center for Drug-Free Schools and Communities

Sharing Your Success, Volume IV

RECOMMENDATION FORM

Sharing Your Success is an annual sourcebook of effective prevention efforts in the Western Regional Center service area. Programs and practices from elementary and secondary schools, Institutions of Higher Education, state agencies, and community organizations are collected and summarized in a format designed to help others initiate new programs or to enhance strategies already in progress. We invite you to use this form to help us identify exemplary programs. We want to know what is working. Help us get the word out! Recommended programs/practices will be contacted by Western Center staff for additional information.

I would like to recommend the following Program/Practice for possible inclusion in ***Sharing Your Success, Volume IV***.

Name of Program/Practice: _____

Contact Person: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (___) _____

Brief description of the Program/Practice and why it should be considered exemplary:

Submitted By:

Name: _____ Title: _____

Organization/Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (___) _____ Date: _____

Send to: Vicki Ertle, Dissemination Specialist
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